rupture of the membranes was an added risk. Obstetric care of a high order by doctors was required during labour; resuscitation measures, including positive-pressure oxygen, should be at hand. (The improved figures for late cerebral complications reported by Professor Lennon were probably due to prevention of anoxia by this means and not to rupture of the membranes *per se*.)

Finally, improvement of the place of the United Kingdom in the perinatal mortality table could follow study of methods in other countries, such as those reported from Alberta by Margaret Hutton (1964).

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Mr J M Brudenell (*King's College Hospital, London*)[1] said that failure of induction of labour was an important clinical problem. When induction was followed by Cæsarean section the obstetrician was sometimes left wondering whether the induction should have been done. Of 526 inductions in one unit at St Luke's Hospital, Bradford, 47 (9·1%) had come to Cæsarean section. The Cæsarean section rate had been approximately twice that in non-induced patients and nearly three times that in Professor Lennon's latest series: the perinatal mortality, on the other hand, had been low, 6 babies only being lost, an uncorrected perinatal mortality rate of 1·1%.

Examination of the indications for Cæsarean section revealed that fœtal distress had occurred in labour in 14 patients and pre-eclampsia had become very severe in 2 patients. There was no evidence that induction had been a contributory factor to the Cæsarean section in these 16 patients. Fourteen patients had failed to go into labour in spite of the usual stimulant measures and induction had certainly been responsible for the Cæsarean section in these. Prolapse of the umbilical cord might have resulted from induction but among the 15 patients who had gone into labour and then failed to progress disproportion had been present in 9, all primigravidæ. Disproportion had also been present in 4 cases where the immediate indication for operation had been fœtal distress and it might have been a contributory factor to the distress. Thus it seemed: (1) Not all patients who had Cæsarean sections following an induction did so as a result of the induction; quite a high proportion would have had the operation anyway. (2) Patients who failed to progress in labour after induction often did so as a result of previously unsuspected disproportion.

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